



AUTHORIZATION TO DISCLOSE PATIENT INFORMATION

IMPORTANT: This form is to be completed by the licensed patient or the legal representative of the patient. This form authorizes disclosure of medical marijuana patient information in the state of Oklahoma.

PATIENT INFORMATION

First Name _____ Middle Name _____ Last Name _____ Suffix _____

Medical Marijuana Patient License # _____ Date of Birth (mm/dd/yyyy) _____

Proof of Identity (select one): OK Driver's License U.S. Passport/U.S. Photo I.D. OK I.D. Card Tribal I.D. Card

Proof of Identity Documentation # (e.g. Drivers License number): _____

INFORMATION TO BE SHARED

(select all that apply):

- Entire Patient Record Patient Application for Licensure Physician Recommendation Form Physician Termination of Patient License Form
- Patient Surrender of License Form Patient Information compiled between _____ and _____
(mm/dd/yyyy) (mm/dd/yyyy)

OTHER: _____

The information may be disclosed for the following purpose(s) only (select all that apply):

- Insurance Continued Treatment Legal At My Representative's Request

OTHER: _____

ATTESTATION I understand that by voluntarily signing this authorization:

- Pursuant to 63 O.S. § 427.7(C), I authorize the Oklahoma Medical Marijuana Authority to disclose my patient records as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to disclose information, I can revoke this authorization at any time. The revocation must be made in writing and delivered to the Oklahoma Medical Marijuana Authority in accordance with the instructions below.
- I understand that signing this authorization will not affect my eligibility for licensure with the Oklahoma Medical Marijuana authority.
- I understand that I cannot restrict information that may have already been shared based on this authorization.
- Information disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by 63 O.S. § 420, 63 O.S. § 427.7, and 63 O.S. § 427.22.
- The information in this recommendation form is true and correct.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event: _____



Signature of Patient, Parent or Legal Representative

Date mm/dd/yyyy

Description of Legal Representative's Authority

Expiration Date (mm/dd/yyyy) If longer than one year from date of signature or no event is indicated